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SUPREME COURT, U.S.
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In The
Supreme Court of the United States

Eric Michael Clark,

Petitioner,

v.

State of Arizona,

Respondent.

On Writ of Certiorari to the Arizona Court of Appeals

AMICUS CURIAE BRIEF OF THE CITIZENS COMMISSION ON HUMAN RIGHTS

In support of Respondent

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I – INTEREST OF AMICUS

Amicus Citizens Commission on Human Rights[1] (CCHR) is a non-profit, public benefit organization dedicated to investigating and exposing psychiatric violations of human rights.

CCHR's members include prominent doctors, lawyers, artists, educators, civil and human rights representatives and professionals who see it as their duty to expose and help abolish physically damaging practices in the field of mental healing. With 250 chapters in 34 countries, CCHR seeks to accomplish these stated aims with like-minded individuals and groups, including politicians, teachers, healthcare professionals, government and law enforcement officers and the media.

CCHR's expertise lies in the study of unscientific diagnosis and labelling and damaging treatment of individuals by the psychiatric profession, including the deleterious effects thereof upon the individual and on our society as a whole. On behalf of thousands of its members and in the interest of persons whose rights and freedoms will not otherwise be heard, CCHR

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1. Letters from the parties consenting to the filing of amicus briefs have been lodged with the Clerk of the Court. In accordance with Rule 37.6, amicus states that no counsel for any party authored or participated in any manner in this brief. No entity or person, aside from amicus, made any monetary contribution to the preparation or submission of this brief.

offers an entirely different perspective than those of the parties or other amici.

II – SUMMARY OF ARGUMENT

This amicus brief addresses in part, the effect upon our judicial system of the burgeoning increase in the purported identification of alleged psychiatric illnesses in recent decades, many of which describe common human behavior and which "illnesses" or "disorders" lack scientific validity. This creation of mental illnesses has resulted in inaccurate, unreliable purchased testimony in criminal matters, and ever expanding diminution of responsibility for intentional criminal acts simply by mischaracterizing the accused as insane.

It is CCHR's position that the State of Arizona acted within its authority to simplify the insanity defense to protect its citizens, to adjudicate responsibility for intentional criminal acts and to avoid the current parade of irrelevant psychiatric testimony confusing to juries and unnecessary to the determination of *mens rea*.

III – ARGUMENT

The parties to this action have fully set forth the factual history of the case, the general law respecting the history of the insanity defense and the important states-rights issues raised by

this Court's acceptance of certiorari. Accordingly, none of these matters will be repeated except briefly where necessary to give context to the arguments.

Forbearance from the imposition of severe criminal penalties against one who, while having committed a violent crime was unaware of his transgression, is exercised by every state in the union. Indeed, if the purpose of punishment is to encourage members of the society to obey the laws of the society, there is little reason to punish one for commission of an act when he was honestly incapable of understanding that he had committed wrong.[2]

Thus, the earliest formulation of the insanity defense in *M'Naghten's* case, 10 Clark & Fin. 200, 210, 8 Eng.Rep. 718, 722 (H.L. 1843) held that to satisfy the requirements for a successful insanity defense, it must be clearly proved that, at the time of the commission of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.

Contrary to the arguments of the petitioner, these two phrases from M'Naghten can easily be read to mean exactly the

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2. Amici does not here address the relatively small categories of laws which, if violated, nevertheless can potentially result in criminal penalties.

concept that the State of Arizona sought to achieve: that a guilty person will not be punished for the commission of a crime requiring *mens rea* if he did not know what he was doing was wrong. One hundred and fifty years of agile-minded defense attorneys creating new arguments, the myriad factual circumstances that have occurred in criminal trials, and the thousands of courts which have sought to interpret that Rule to such circumstances have necessarily lead to confusion.

The State of Arizona, having experienced the same sorts of defense gambits and psychiatric testimony that every federal and state court has experienced, chose to exercise its constitutional authority to simplify and make workable the insanity defense. By so doing, Arizona chose to exclude, where possible, purchased testimony of unusual purported "disorders" that have baffled judges and juries within its borders.

This brief focuses on why the insanity defense has *become* so complex; and how it has become so far removed from its central purpose of forbearance of punishment of persons who lacked *mens rea*.

A. The Introduction of Organized Psychiatry Into the Determination of Right vs. Wrong

At the time of *M'Naghten's* case, psychiatry as a profession did not exist. There were what was known as "alienists" and some practitioners focusing upon mental

disturbances, but in general, a jury of one's peers was deemed the appropriate arbiter of whether an accused was so afflicted that he was unable to differentiate between right and wrong.

In the 1930's, the practice of psychiatry was still little known, little used, and little taught, with only a handful of universities conferring degrees therein. However, the leaders of the relatively new practice aggressively sought, through legislation, promotion of their claimed expertise and society's need for their services, to expand its numbers and its influence.

Leaders of the international psychiatric associations and the American Psychiatric Association later proclaimed their intention to change the moral standards of our society, and bring about "the re-interpretation and eventually eradication of the concept of right and wrong," as the proper objectives for psychiatry and "effective psychotherapy." In a series of public lectures in 1945, G. Brock Chisholm, who, with John Rawlings Rees was co-founder of the World Federation for Mental Health (WFMH), bluntly told their peers: "If the race is to be freed from the crippling burden of good and evil it must be psychiatrists who take the original responsibility." [3]

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3. G. Brock Chisholm, "The Reestablishment of Peacetime Society: The Responsibility of Psychiatry," William Alanson White Memorial Lectures, Second Series, 23 Oct. 1945, *Psychiatry: Journal of Biology and Pathology of Interpersonal Relations*, Vol. 9, No. 1, Feb. 1946, p. 9.

Nowhere was purported psychiatric expertise more accepted than in American courtrooms, and nowhere were its doctrines more dramatic than in determining the scope of responsibility for criminal acts.

B. Establishment of a Psychiatric Manual and its Use in Judicial Proceedings

In accordance with the policies and goals addressed above, the American Psychiatric Association established a "manual" or dictionary to be utilized in the classification of supposed mental ills. The manual resulted in the identification of numerous "mental disorders," thus permitting the diminution of personal responsibility by identifying a large number of reasons why persons were not personally responsible for their criminal conduct: they had an "illness," "mental disease"or "disorder" that caused the criminal act and which was outside of the individual's volitional control.

The first version of this dictionary, published by the APA in 1952, was denominated the *Diagnostic and Statistical Manual of Mental Disorders*, or colloquially, the "*DSM*." The *DSM* listed and categorized 112 supposed mental disorders by several committees of psychiatrists supposedly knowledgeable in the area. It should be noted at the outset that what has been called a "mental disease" or a "mental illness" has never been shown to be either an actual disease or illness. An actual disease has

measurable and palpable pathological abnormality, and are the diseases treated by physicians. This is not so with so-called mental diseases. No blood test, radiological scan or physical examination has ever revealed the existence of any mental disease or "disorder."

Although the *DSM* did not define what a "mental disorder" actually was, it leant substantial credibility to the concept that at least there were vast numbers of mental disorders which psychiatrists, as purported experts in the filed, could readily identify and classify. Because the prevailing rule in determinations of insanity as a criminal defense was based on whether a person who committed a crime possessed an overwhelming mental illness, the expanding number of mental disorders offered a potpourri of tools to so convince the jury.

Thus, in the period of percolation of the new manual, the District of Columbia Circuit ruled on the case of *Durham v. United States*, 214 F.2d 862 (D.C. Cir.1954), broadening the ability of psychiatrists to provide expert testimony on issues substantially beyond the scope of *M'Naghten*. In *Durham*, the defendant, a man with a long criminal and psychiatric history, was tried and convicted of housebreaking despite his insistence that he was not guilty by reason of insanity. The Court reversed, holding that "an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect."

Durham, 214 F.2d at 874-75. (footnote omitted).

This "product" test as it came to be known, was eventually overruled in *United States v. Brawner*, 471 F.2d 969 (D.C. Cir.1972) (en banc), in favor of a hybrid rule influenced by *Durham* which was proposed by the American Law Institute. The ALI model rule held that a "person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law." Model Penal Code § 4.01(1) (Final Draft 1962) (quoted in *United States v. Hansen*, 701 F.2d 1078, 1080 n. 3 (2d Cir.1983)).

The *Durham* decision and subsequent hybrid ALI rule established solidly the need for psychiatric testimony in criminal proceedings and set the precedent for the admission of psychiatric testimony in the rest of the world to explicate the supposed nature of insanity. With claimed expertise in the characterization of conduct as mental illness (or not), psychiatric witnesses were, after *Durham*, permitted to utilize a broad and complex test beyond the ken of lay jurors which substantially diverged from the central concept of the accused's ability to differentiate between right and wrong.

Indeed, the *Durham* decision triggered a steady increase of psychiatric courtroom testimony in the U.S., which as shown

below, has resulted in a massive erosion in the justice system's ability to provide predictable and equitable justice.

Psychiatrists became the arbiters of culpability for criminal deeds based not upon the defendant's volitional decision to act or forbear from acting, but rather, whether the accused possessed a purported "mental disorder" that the psychiatrist utilized to excuse anti-social conduct, regardless of intent.

Only three years later, in 1957, Justice Fortas, at the time a criminal defense attorney, assessed the impact of the *Durham* decision stating: "...[T]he law has recognized modern psychiatry....Its importance is that it is a charter, a bill of rights, for psychiatry and an offer of limited partnership between criminal law and psychiatry." [4]

C. Expansion of the *Diagnostic and Statistical Manual* Further Confused Sanity Adjudications

The *DSM* was not based upon medical tests, studies or scientific experiments. It was predicated entirely upon the opinions of psychiatrists appointed to committees to address and list the criteria for classifying a person as mentally ill.[5] "Unlike

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4. *American Journal of Psychiatry,* 113:577-582, 579 (Jan 1957)

5. Caplan, P., *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal.* Addison-Wesley

medical diagnoses that convey a probable cause, appropriate treatment and likely prognosis, the disorders listed in *DSM-IV* are terms arrived at through peer consensus" – literally by a vote by APA committee members – and designed largely for billing purposes. [6] In other words, there is no objective science to it.

Like any assertion based upon consensus of a committee in any venue or discipline, the criteria for diagnosis of each mental disorder was ambiguous and therefore easily susceptible to mere opinion.

Subsequent revisions of *DSM* after the original 1952 version only broadened the scope of what was considered mental illness. In 1968, *DSM II* was published. There, the listing of supposed mental disorders grew from the 112 classified in 1952, to 163 purported mental disorders. The section on *DSM II* addressing the disorder claimed to afflict petitioner in the instant case, schizophrenia, conceded that, "[e]ven had it tried, the [schizophrenia] Committee could not establish agreement about what this disorder is; it could only agree on what to call it."[7]

The situation worsened in subsequent editions, with the

Pub.Co., p. 85-110 (1995)

6. Dr. Tana Dineen, Ph.D., *Manufacturing Victims*, Third Edition, (Robert Davies Multimedia Publishing, Quebec, Canada, 2001), p. 86;

7. *DSM II*, p. ix.

1980 version, denominated *DSM III,* which swelled the list to 224 mental disorders. The American populace was allegedly becoming more and more severely mentally ill in many different ways – according to the APA. In 1987, the American Psychiatric Association published a further revised *DSMIIR* in support of its members' business, now asserting the existence of a whopping 253 mental disorders.[8]

D. DSM Disorders Are Not Actual Diseases

In evident justification for the burgeoning number of claimed mental disorders, *DSM III* conceded, in its Introduction under the heading, "Basic Concepts," that "[a]lthough this manual provides a classification of mental disorders, there is no satisfactory definition the specifies precise boundaries for the concept 'mental disorder' ..." *DSM III* goes on to admit that it does not assert that these identified "disorders" are actually mental illnesses, much less that the disorders are either out of the control of the individual or that they emphatically ordain his conduct in a fashion that absolves him from responsibility therefrom. Rather, it states,

> In DSM-III each of the mental disorders is

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8. Lobbying efforts of the APA with insurance companies required that numbered *DSM* diagnoses accompany billings for psychiatric services. Thus, the business aspect of the ever-expanding number of psychiatric illnesses served an obvious purpose beyond purported academic discussion.

> conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful syndrome (distress) or impairment in one or more important areas of functioning (disability). In addition, there is *an inference* that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society.[9]

The fourth edition, *DSM IV*, was published by the APA in 1994, and balloons the number of mental disorders "found" to *374 disorders*.[10] And, like its previous editions *DSM* continues to concede that its profession remains unable even to define the term mental disorder, noting that the term "mental disorder" continues to appear in the volume "because we have not found an appropriate substitute."[11] It also notes, "Moreover, although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of 'mental disorder."[12] This further admission is significant, because in recent years, the *DSM* and its authors and publishers from the

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9. *Diagnostic & Statistical Manual for Mental Disorders - III*, American Psychiatric Association, 1980, p. 5-6 (emphasis added).

10. *Id.*

11. *Id.*, p. xxi.

12. *Id.*, p. xxi.

American Psychiatric Association have been under substantial pressure both to justify this burgeoning list of purported disorders, and indeed, to explain the lack of science in their classifications and testimony arising therefrom.

Notwithstanding the inference that the identified disorders presented actual illnesses, psychiatric practice has never demonstrated the existence of any actual physical illness associated with the myriad listings of mental disorders.

Thus, the APA authors state quite clearly in the various editions that they have no idea what a mental disorder is; they can't define it nor can they distinguish between mental disorders, and no mental disorder; and they have no scientific proof of the *existence* of the "disorders."[13] However, these failings have presented no barrier to diagnosis to the "expert" seeking to absolve violent criminals from responsibility for their acts. To the contrary, such ambiguities permitted psychiatric diagnoses of the existence of mental illnesses which – in the view of the retained psychiatric witness – may be sufficient to excuse an intentional crime as an impulse beyond the purported ability of

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13. The year *DSM IV* was published, Norman Sartorious, later president of the APA (1996-1999), declared at a meeting of a congress of the Association of European Psychiatrists, "The time when psychiatrists considered that they could cure the mentally ill is gone. In the future the mentally ill have to learn to live with their illness." Lars Boegeskov, "Mentally Ill Have to Have Help – Not to Be Cured," *Politiken*, September 19, 2004.

the accused to suppress.

As noted by Professors Herb Kutchins (California State University Sacramento) and Stuart Kirk (UCLA), authors of *Making Us Crazy: DSM: the Psychiatric Bible and the Creation of Mental Disorders*,[14] mental disorders described in *DSM* were created in accordance with the opinions and beliefs of the managers of the publication:

> First, you must appreciate that the notion of mental disorder is what social scientists call a construct. Constructs are abstract concepts of something that is not real in the physical sense that a spoon or motorcycle or cat can be seen and touched. Constructs are shared ideas, supported by general agreement. Democracy, alienation, conservatism are constructs, abstract ideas that have some degree of shared meaning within some groups Mental illness is a construct, a shared abstract idea. ... be aware that constructs such as generalized Anxiety Disorder are held together by agreements and that agreements change over time. The category itself is an invention, a creation. It may be a good and useful invention, or may be a confusing one. DSM is a compendium of constructs. And, like a large and popular mutual fund, DSM's holdings are constantly changing as the manager's estimates and beliefs about the values of those holdings change.

Id., p. 23-24.

Because these constructs are whimsical, common behavior of humans can, at the whim or opinion of the

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14 Simon & Schuster (1997)

psychiatric observer, be viewed as either entirely normal or an entirely abnormal mental disorder.

For example, the *DSM* dramatically changed in accordance with pressure to conform to "politically correct" ideas. In *DSM II*, homosexuality was the first of 10 specifically identified categories in section 302, "Sexual deviations." In 1968, protestors from the Gay Liberation Front demonstrated at the AMA convention and in 1970 to 1973 at APA conventions, and otherwise lobbied against inclusion as a mental disorder. [15] *DSM III* eliminated the characterization, replacing it with a diagnosis only for a disorder for those purportedly "troubled" with their homosexual impulses. Finally, after further lobbying efforts and protests in *DSM III*, all such references were deleted in their entirety. [16]

In the opposite fashion, lobbying efforts caused the supposed mental disorder, Post Traumatic Stress Disorder to be *included* into the *DSM*. The original version contained "Gross Stress Reduction," the diagnosis used for "battle fatigue" as was attributed to distressed soldiers during World War II. However, the term was deleted in *DSM II*, to the argued detriment of some Vietnam War veteran groups seeking disability payments for former soldiers. Thus, after a period of intense lobbying, a new

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15. Kutchins & Kirk, p. 63, 65.

16. *Id.*, p. 78-79.

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diagnostic criteria was inserted in *DSM III* literally in negotiations with veterans groups who demanded their own category: Post Traumatic Stress Disorder.[17]

As another example of how common activities can be deemed mental illnesses in *DSM*, consider the plight of a lawyer who worries about the quality and acceptance by the Court of his upcoming oral argument. A review the target attorney's apprehension against the broad criteria of at least the following *DSM IV* categories could quickly and easily be made to "diagnosis" whether the distressed attorney was suffering from a mental disorder or one of the numerous "sub" disorders, and if so, which one:

* Panic Disorder with Agoraphobia,[18] *DSM IV*, p. 396-402
* Panic Disorder without Agoraphobia, *id.*, p. 402-403
* Agoraphobia without History of Panic Disorder, *id.* 403
* Specific Phobia (replacing the former Simple Phobia), *id.*, p. 405-406
  - Natural Environment Type (e.g., fear of storms, water, heights), *id.*, p. 406
  - Situational Type (e.g., fear of tunnels, bridges, flying, elevators, [perhaps courtrooms], etc.), *id.*, p. 406
  - "Other" Type ("cued by 'other' stimuli"), *id.* p. 407

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17. *Id.*, p. 101-115.

18. Agoraphobia is defined as a fear of being in difficult or helpless situ

* Social Phobia (fear of a social or performance situation [perhaps courtrooms]), *id.*, p. 411
* Obsessive-Compulsive Disorder
* Generalized Anxiety Disorder
* Anxiety Disorder Due to a Medical Condition, *id.* p. 394
  - With Generalized Anxiety, *id.* p. 393-94
  - With Panic Attacks, *id.* p. 394
  - With Obsessive-Compulsive Symptoms, *id.* p. 393
* Substance-Induced Anxiety Disorder, *id.* p 439-443
  - With Generalized Anxiety, *id.* p. 440
  - With Panic Attacks, *id.* p.440
  - With Obsessive-Compulsive Symptoms, *id.* p. 440
  - With Phobic-Symptoms, *id.* p. 440

Id., Kutchins & Kirk, p. 25-26.

Or perhaps, if a psychiatrist was retained to label the apprehensive attorney with any of the above listed disorders but was unable to make a neat fit, then one of the catch-all disorders listed in *DSM* could be employed, such as the ubiquitous "Anxiety Disorder Not Otherwise Specified." *Id.* p. 444

A psychologist who attended a DSM committee meeting presided over by the manual's leading architects, psychiatrist Robert Spitzer, reported, "[T]hey were having a discussion for a criterion about Masochistic Personality Disorder and Bob Spitzer's wife, [a social worker and the only woman on Spitzer's

side at that meeting] says, "I do that sometimes," and he says, "Okay, take it out." You watch this and you say, "Wait a second, we don't have a right to criticize them because this is a "science?" [19]

As reported in detail by another of the APA committee members who participated in the creation on *DSM IV*, the process more closely resembles political jockeying of the language of a legislative bill to gain consensus than any true scientific endeavor. [20]

One might assume that the advance of science in essentially all disciplines in recent years would bespeak a growing ability of the psychiatric profession to understand and identify the mental illnesses about which thousands of their number testify in criminal settings throughout the country. Not so, according to three of the APA's primary authors of *DSM IV*. As might be expected, another *DSM* version is under preparation. And a book about it was recently published by the APA entitled *A Research Agenda For DSM - V*. The authors unashamedly admit that there remains no etiological foundation for any of the purported mental disorders listed in any of the prior versions of

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19. Caplan, P. *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal.* Addison-Wesley Pub.Co., p. 91. (1995)

20. *Id.*, p. 80-115.

the book:

> The DSM-III diagnostic system adopted a ... approach to diagnosis ... around hypothetical but unproven theories about etiology in favor of a descriptive approach, in which disorders were characterized in terms of symptoms that could be elicited by patient report, direct observation and measurement... From the outset, however, it was recognized that the primary strength of a descriptive approach was its ability to improve communication between clinicians and researchers, not to establish its validity.
>
> Disorders in DSM-III were identified in terms of syndromes, symptoms that are observed in clinical populations to covary [sic] together in individuals. It was presumed that, as in general medicine, the phenomenon of symptom covariation could be explained by a common underlying etiology... Once fully validated, these syndromes would form the basis for the identification of standard, etiological homogenous groups that would respond to specific treatments uniformly.
>
> In the more than 30 years since the introduction of ... DSM-III, the goal of validating these syndromes and discovering common etiologies has remained elusive.[21]

Similarly, the APA put out a press release in 2003 in response to criticism of the lack of science to its diagnoses, but which conceded, "In the absence of one or more biological markers for mental disorders, these conditions are defined by a

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21. Kupfer, First & Regier, *A Research Agenda For DSM - V*, American Psychiatric Association, 2002, p. xviii.

variety of concepts." [22]

In other words, the leaders of the psychiatric profession list these many alleged illnesses not because they are palpable illnesses for which any etiology or physical cause van be found, but rather, to make it easier to communicate with each other.

Unfortunately, these same purported experts are the gatekeepers utilized in the judicial system to make complex determinations in many states, whether the criminal defendant is responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law." ALI Model Penal Code § 4.01(1) The discipline of psychiatry is simply *unable* to do that – notwithstanding the numerous experts permitted to swear the opposite in courts across the nation. This inability and the commensurate lack of ethical standards by the supposed experts has resulted in countless outlandish defenses for half a century – which the State of Arizona justifiably wishes in the future to avoid.

Examples of criminal defenses from *DSM* categories which any logical citizen would consider bizarre include:

* Telephone scatalogia (302.90): A psychiatrist argued that

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22. "American Psychiatric Association Statement on Diagnosis and Treatment of Mental Disorders." Release 03-39, September 25, 2003.

the president of American University after being arrested for making obscene phone calls, suffered from paraphilia (perverted sexual behavior). [23]

* Sleepwalking disorder (307.46): This diagnosis was used successfully in the defense of a man charged with the murder of his wife's parents, after he drove 15 miles in the middle of the night to commit the act.[24]

* Somatoform disorder (330.81): A university professor was ordered to pay his adult daughter $1500 per month until he retires because she is unable to work due to a "disorder" that makes her focus on her physical disability.

While even the 374 categories of purported mental disorders presently located in *DSM IV* should be enough to fulfil the needs of the defense bar and its willing and inventive psychiatric witnesses, even more disorders are periodically created to escape criminal culpability. For example:

* Clerambault-Kandinsky syndrome: A psychologist testified that a judge of New York State, charged with extortion and threatening to kidnap the teenage daughter of his ex-lover, "was manifesting advanced symptoms of CKS," described as

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23. Dineen, Dr. Tana, *Manufacturing Victims: What the Psychology Industry if Doing to People*, Robert Davies Publishing, p. 213 (1966)

24. *Id.*

involving an irresistible lovesickness or "erotomania." [25]

* Cultural psychosis: A defense lawyer in Milwaukee argued that a teenage girl charged with the shooting and killing of another girl during an argument over a leather coat suffered from "cultural psychosis" which caused her to think that problems are resolved by gunfire.[26]

* Urban psychosis: Man who grew up in a violent family in a tough neighborhood in Milwaukee who had been assaulted as a child and gang-raped in prison, stabbed a sexual partner to death after an alleged flash-back to the rape.[27]

* Urban survival syndrome: Teenage defendant argued that "urban survival syndrome" caused him to gun down two other teenagers with whom he was feuding. The accused had admitted killing the victims, but asserted he had been threatened by them with a shotgun a week earlier.[28]

* Fan Obsession Syndrome: First invoked by psychiatrist

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25. *Id.*

26. *Id.*

27. Falk, P.J., "Novel Theories of Criminal Defense Based upon the Toxicity of the Social Environment: Urban Psychosis, Television Intoxication and Black Rage." *North Carolina Law Review*, 74 N.C.L.R.731 (1996)

28. Hagen, M., *Whores of the Court: The Fraud of Psychiatric Testimony and the Rape of the American Justice System*, Regan Books, 1997, p. 165

Park Elliot Dietz in 1992 to defend Robert Bardo who murdered actress Rebecca Schaeffer. [29]

* Gone with the Wind Syndrome: Used by rape experts to explain why rapists believe sex has to be spontaneous and done after some resistance on the part of the woman.[30]

* Super Jock Syndrome: Which formed a part of the O.J. Simpson trial. Dr. Susan Forward, the therapist who treated Simpson's murdered wife, Nicole, testified for the prosecution that the likelihood of Simpson's guilt was based on her theory that athletes, especially superstars, are prone to violence when frustrated. [31]

* Accounting Anxiety: A psychologist claimed he suffered from "accounting anxiety" to explain why he had violated financial and tax laws. [32]

* Moral Insanity: In 1998, psychiatrist William Cone was

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29. "Yes, but is he crazy? Forensic experts help jury decide if defendant is madman or criminal." *The Washington Times*, March 4, 1992.

30. "The Rape Debate: Is There an Epidemic of Sexual Assaults? Or Just a Wave of Politicized Hysteria? From Bedroom to Courtroom, the Rules Are Changing." *Los Angeles Times*, October 17, 1993.

31. "Simpson Case Could Serve as Warning" *Indianapolis Recorder*, August 13, 1994

32. "Psychologist Blamed Accounting Anxiety" *Nettavisen*, April 29, 2003.

convicted of sexual and deviate sexual assault of two female patients. Cone claimed that he suffered from "moral insanity" brought on by his "obsessive preoccupation with work, power and perfection...." [33]

One can readily see the wisdom of a State's exclusion of such assertions by an accused to escape criminal culpability, with the statutory limitation imposed in Arizona that, "Conditions that do not constitute legal insanity include but are not limited to momentary, temporary conditions arising from the pressure of the circumstances, moral decadence, depravity or passion growing out of anger, jealousy, revenge, hatred or other motives in a person who does not suffer from a mental disease or defect or an abnormality that is manifested only by criminal conduct." Arizona Penal Code § 13-502(A)

While the above list of "mental illnesses" utilized to escape criminal responsibility is outlandish, many of the newly created illnesses have become household words and are rarely questioned, although they should be. One is "Battered Woman Syndrome." The battered woman syndrome has increasingly been invoked in trials in which a wife or girlfriend of the victim is charged with murdering a spouse, by *inter alia,* setting fire to his bed as he lies passed out, or shooting him as he sleeps.

Yet this type of crime could hardly be one in which the

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33. "133-Year Prison Sentence For Cone," *Daily Quill*, 11 Feb. 1998.

woman would not understand the nature of her conduct, planning and executing a murder with gasoline, and doing it when she was reasonably assured that the alleged wife-beater would not be able to defend himself. Moreover, laws of every jurisdiction provide substantial protection to women from an allegedly battering male, through a judicial protective order enforced by the police or criminal prosecutions. Presumably perceiving state-mandated remedies as inadequate, the battered woman takes matters into her own hands, and – bluntly – commits murder. Yet, one law review article reviewing this class of cases found that in one third of the cases in which the defense was presented, the accused was acquitted. [34]

Chief among the well-accepted newer syndromes utilized to escape criminal culpability, is Post Traumatic Stress Disorder addressed above, or as it is now widely known, "PTSD." *DSM III* characterized PTSD as the development of specific symptoms following a psychologically traumatic event that is beyond the range of usual human experience. PTSD is not limited to veterans; anyone may allegedly be susceptible, as *DSM III* suggests, such as victims of traumatic events like rape, assault, airplane crashes, and torture. *See, DSM III,* p 236-238.

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34. Stark, E., "Symposium on Reconceptualizing Violence Against Intimate Partners: Critical Issues: Re-Presenting Women Battering: Women Syndrome to Coercive Control." *Albany Law Review* 58:973

One law review article addressing the issue found widespread use of PTSD among Vietnam veterans accused of a crime, and noted its effectiveness as a defense:

> Although PTSD has received a mixed reception in the legal community, it has achieved some success as a legal defense. Vietnam veterans have used PTSD successfully as an insanity defense against charges of murder, attempted murder, kidnaping, and drug smuggling. PTSD has also been used to mitigate sentences in convictions for crimes such as drug dealing, manslaughter, assault with intent to commit murder, and even tax fraud. In light of the relative rarity of the insanity defense in general and the unlikelihood of its success, the success of PTSD as an insanity defense is intriguing.

29 *Wm. & Mary L. Rev.* 415, 422-23 (1988)

The law review article provides helpful tips to the attorney considering the PTSD defense in inflaming the emotions of the jurors to buy the defense, including that, "[f]ilm footage of Vietnam may prove useful in assisting the trier of fact to appreciate the trauma of combat fully." *Id.*, at 437.

Perhaps the best proof of the disingenuous nature of psychiatric opinion testimony concerning sanity is the fact that experts are so readily available for flatly opposing positions.

In a 1962 article in the *Northwestern Law Review*, psychiatrist Alfred Baur cited a case where his hospital received a patient for a three-month observation before trial. Baur and

two colleagues concluded that he had "no mental disorder." The court, however, appointed two private psychiatrists to give their expert opinion. One announced that the patient was a paranoid schizophrenic; the other said he was in a paranoid state. Come the trial, the hospital psychiatrists testified that the patient was not insane, while the two court-appointed psychiatrists insisted that he was. The final irony in this situation was, as Baur reported, was that the jury found the man 'not guilty by reason of insanity' and 'still insane' and then committed him to the hospital which had just found him without mental disorder. [35]

Jeffery Harris, Executive Director of the U.S. Attorney General's Task Force on Violent Crime, observed, "What amazes me is that in any trial I've ever heard of, the defense psychiatrist always says the accused is insane, and the prosecuting psychiatrist always says he's sane. This happened invariably, in 100% of the cases, thus far exceeding the laws of chance. You have to ask yourself, 'What is going on here?' The insanity defense is being used as a football...and quite frankly, you'd be better off calling Central Casting to get 'expert psychiatric testimony' in a criminal trial." [36] In this regard, as

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35. Alfred K. Baur, M.D., "Legal Responsibility and Mental Illness," *Northwestern Univ. Law Review*, Vol. 57, No. 1, Mar.-Apr. 1962.

36. Carol A. Gallo, "The Insanity of the Insanity Defense," *The Prosecutor*, Spring 1982, p. 6.

noted by author Thomas Szasz, M.D.:

> It is unlikely that toxicologists would be tolerated in courts of law if one would observe that he found a large quantity of arsenic in the body of a deceased person, and another stated that he found by the same operation none. Yet this sorry spectacle is commonplace in regard to psychiatric findings." [37]

IV - CONCLUSION

According to *DSM-IV*, when its mental disorder descriptions "are employed for forensic purposes, there are significant risks that diagnostic information will be misused and misunderstood." [38]

Yet, every jurist has observed the amorphous testimony of psychiatric experts and contradictions between the witnesses regarding psychiatric testimony and the resulting confusion therefrom. As noted in a dissenting opinion by future Chief Justice Warren Burger, in *Blocker v. U.S.*, 288 F.2d 853, 860 (D.C.Cir. 1961) concerning the lack of a scientific basis for psychiatrists' conflicting testimony, "No rule of law can possibly be sound or workable which is dependent upon the terms of another discipline whose members are in profound

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37. Thomas Szasz, M.D., "Psychiatric Expert Testimony—Its Covert Social Function," *Psychiatry, Journal for the Study of Interpersonal* 20, No. 3, August 1957, 314.

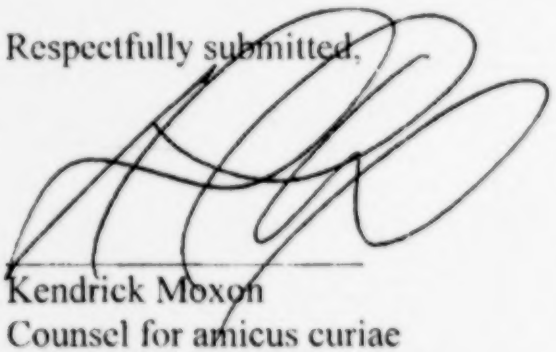
38. *DSM IV*, p. xxiii.

disagreement about what those terms mean."

In the 54 years since the *DSM* was published, and the 52 years since the *Durham* case opened the door wide to the introduction of psychiatric testimony on insanity issues, there has not only been no advance – the field is muddled beyond redemption. The State of Arizona having devised a means to provide predictable criminal justice while honoring the rights of its citizens and sufficiently preserving the rights of criminal defendants, its laws should be found to be constitutional and should be preserved.

Dated: March 5, 2006

Respectfully submitted,



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ON HUMAN RIGHTS

PROOF OF SERVICE

I hereby certify that the Brief Amicus Curiae of the Citizens Commission on Human Rights, was sent by First Class Mail, postage prepaid, on March 5, 2005, to the following

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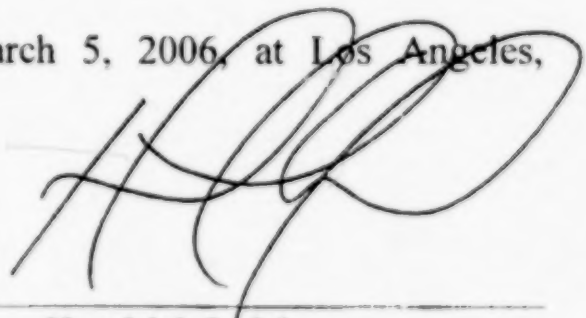
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I certify and declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on March 5, 2006, at Los Angeles, California.



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